

Proposed Rule
LSA Document #07-150

DIGEST

Amends [405 IAC 1-14.6-6](#) and [405 IAC 1-14.6-23](#) to revise Medicaid reimbursement methodology for payment to nursing facilities, change the annual rate effective date to July 1 for all providers, impose a maximum annual rate increase of 5% per annum, before adjusting for case mix, and impose a per day rate reduction for SFY 08-09. Effective 30 days after filing with the Publisher.

[IC 4-22-2.1-5 Statement Concerning Rules Affecting Small Businesses](#)

[405 IAC 1-14.6-6](#); [405 IAC 1-14.6-23](#)

SECTION 1. [405 IAC 1-14.6-6](#) IS AMENDED TO READ AS FOLLOWS:

[405 IAC 1-14.6-6](#) Active providers; rate review

Authority: [IC 12-8-6-5](#); [IC 12-15-1-10](#); [IC 12-15-21-2](#)

Affected: [IC 12-13-7-3](#); [IC 12-15](#)

Sec. 6. (a) The:

(1) normalized average allowable cost of the median patient day for the direct care component; and the
(2) average allowable cost of the median patient day for the indirect, administrative, and capital components;
shall be determined once per year for each provider for the purpose of performing the provider's annual rate review.

(b) The:

(1) normalized allowable per patient day cost for the direct care component; and the
(2) allowable per patient day costs for the therapy, indirect care, administrative, and capital components;
shall be established once per year for each provider based on the annual financial report.

(c) **Beginning October 1, 2007**, the rate effective date of the annual rate review shall be the first day of **October 1 that falls after the second first** calendar quarter following the provider's reporting year-end. **Beginning July 1, 2008, the rate effective date of the annual rate review shall be the first July 1 that falls after the first calendar quarter following the provider's reporting year-end. The rate effective date of the annual rate review for all providers shall be July 1 of each year thereafter.**

(d) Subsequent to the annual rate review, the direct care component of the Medicaid rate will be adjusted quarterly to reflect changes in the provider's case mix index for Medicaid residents. If the facility has no Medicaid residents during a quarter, the facility's average case mix index for all residents will be used in lieu of the case mix index for Medicaid residents. This adjustment will be effective on the first day of each of the following three (3) calendar quarters beginning after the effective date of the annual rate review.

(e) The case mix index for Medicaid residents in each facility shall be:

(1) updated each calendar quarter; and ~~shall be~~

(2) used to adjust the direct care component that becomes effective on the second calendar quarter following the updated case mix index for Medicaid residents.

(f) All rate-setting parameters and components used to calculate the annual rate review, except for the case mix index for Medicaid residents in that facility, shall apply to the calculation of any change in Medicaid rate that is authorized under subsection (d).

(g) When the number of nursing facility beds licensed by the Indiana state department of health is changed after the annual reporting period, the provider may request in writing before the effective date of their next annual rate review an additional rate review effective on the first day of the calendar quarter on or following the date of

the change in licensed beds. This additional rate review shall be determined using all rate-setting parameters in effect at the provider's latest annual rate review, except that the number of beds and associated bed days available for the calculation of the rate-setting limitations shall be based on the newly licensed beds.

(Office of the Secretary of Family and Social Services; [405 IAC 1-14.6-6](#); filed Aug 12, 1998, 2:27 p.m.: 22 IR 73, eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2243; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Mar 18, 2002, 3:30 p.m.: 25 IR 2468; filed Oct 10, 2002, 10:47 a.m.: 26 IR 712; filed Jul 29, 2003, 4:00 p.m.: 26 IR 3872)

SECTION 2. [405 IAC 1-14.6-23](#) IS AMENDED TO READ AS FOLLOWS:

[405 IAC 1-14.6-23](#) Limitation to Medicaid rate increases for nursing facilities

Authority: [IC 12-8-6-5](#); [IC 12-15-1-10](#); [IC 12-15-21-2](#)

Affected: [IC 12-13-7-3](#); [IC 12-15](#)

Sec. 23. (a) Notwithstanding all other provisions of this rule, for the period ~~January 1, 2006~~, **October 1, 2007**, through June 30, 2007, **2009**, nursing facility rates that have been calculated under this rule shall be reduced by five dollars (~~\$5~~) **one dollar (\$1)** per resident per day.

(b) Notwithstanding all other provisions of this rule, for the period **October 1, 2007**, through June 30, 2009, nursing facility rates that have been calculated under this rule shall be limited to a maximum allowable increase of five percent (5%) per annum as follows:

- (1) The normalized allowable cost for the direct care component shall be limited to a maximum allowable annualized increase of not more than five percent (5%). Changes in a provider's Medicaid direct care component rate due to changes in their Medicaid case mix index shall not be limited by the five percent (5%) maximum allowable annualized increase.
- (2) The sum of a provider's indirect care component, administrative component, capital component, therapy component, nursing home report card score rate add-on, special care unit rate add-on, quality assessment rate add-on, less the rate reduction in this section, as applicable, shall be limited to a maximum allowable annualized increase of not more than five percent (5%).
- (3) A provider's annual Medicaid rate may be in effect for longer or shorter than twelve (12) months. In such cases, the maximum allowable annualized rate increase of five percent (5%) shall be proportionately increased or decreased to cover the actual time frame their previous annual rate was in effect, using a twelve (12) month period as the basis.
- (4) Should a provider's quality assessment rate change, the provider's previous Medicaid quality assessment rate add-on shall be restated using the new quality assessment rate, applying all provisions of this rule, for purposes of calculating the maximum allowable annualized increase.

(Office of the Secretary of Family and Social Services; [405 IAC 1-14.6-23](#); filed Apr 24, 2006, 3:30 p.m.: 29 IR 2983)

[Notice of Public Hearing](#)

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